Payment Error Rate Measurement (PERM)

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LAW AND REGULATION

- The Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, enacted on November 26, 2002, requires the heads of Federal agencies to annually review programs they oversee that are susceptible to significant erroneous payments.
- The Office of Management and Budget (OMB) identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments.
- The Centers for Medicare and Medicaid Services (CMS) developed the PERM program to comply with these requirements.

CYCLE 2 STATES

- Seventeen (17) states are individually measured every three (3) years and state error rates are statistically calculated.

- Cycle 2 states:
  - Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont, West Virginia

GOAL and METHODOLOGY

- Goal of PERM is to measure and report an unbiased estimate of the true error rate for Medicaid and KCHIP Fee for Service (FFS), Managed Care (MC) and Eligibility.

- CMS uses federal contractors to conduct the audits.
  - Statistical contractor: Lewin
  - Review contractor: A Plus Government Solutions

- CMS uses a statistically valid methodology that samples a small subset of payments and then extrapolates to the "universe" of payments.

RANDOM SAMPLE

- A random sample of claims from the quarterly Medicaid FFS, KCHIP FFS, Medicaid MC, and KCHIP MC universes are submitted by the states.
- The annual sample sizes are state-specific based on the prior cycle error rates.
- FY 2013 margin of errors and payment variation were reviewed by CMS to determine if smaller or larger sample sizes will be required to meet the precision goals established for the FY 2016 PERM cycle.

FY 2013 PERM AUDIT

- The number of School Based Health Services (SBHS) claims that were randomly pulled for review in FY2013 was 119 records.
- Of those reviewed, two (2) were deemed errors due to:
  1. No submitted documentation. The student record could not be located.
  2. Insufficient documentation. The student was not seen on date of service that was billed.
- Overall great FY 2013 SBHS PERM audit!

FY 2016 PERM AUDIT

- FY 2016 kicks off August 27, 2015 with a CMS and State conference call.
- The state will submit quarterly samples of paid and denied Medicaid and KCHIP claims to the CMS statistical contractor.
- Audited claims will have paid and denied dates beginning with October 1, 2015 through September 30, 2016.

MEASURED COMPONENTS

PERM reviews consist of three (3) components of Medicaid and KCHIP

- •**Fee-For-Service (FFS)**
  - State submits a FFS detailed claims sample to Lewin, statistical contractor
  - A Plus Government Solutions conducts medical review & data processing reviews on sampled FFS claims.
- **Managed Care**
  - Sample consists of at-risk capitated payments
  - A Plus Government Solutions conducts data processing reviews (no medical review) on sampled managed care payments.
- **Eligibility** - FY2016 no eligibility reviews will be conducted, but states will instead participate in Medicaid and KCHIP eligibility Pilots.

ERROR CALCULATION

- The statistical contractor calculates state specific error rates and a national error rate is determined from this subset of 17 states component error rates.

- NOTE: The error rate is not a “fraud rate,” but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements.

FY 2016 PERM AUDIT

- Kentucky's FY 2016 approximate sample sizes are as follows:
  - KCHIP Component
    - FFS - 352, MC - 240
  - Medicaid Component
    - FFS -960; MC - 240

FY 2016 TARGET ERROR RATES

- Medicaid — Overall Target Rate: 0.14%
  - FFS – 3.91%
  - MC – 0%
- KCHIP — Overall Target Rate: 1.67%
  - FFS – 2.75%
  - MC – 0%

MEDICAL RECORD REQUEST

- The contractors collect state Medicaid and KCHIP policies that are used for the medical and data processing reviews.
- Providers will be initially contacted by A Plus Government Solutions to attain the name, phone and fax number of the person handling PERM requests.
- Sometimes the designee is different than the correspondence address contact you listed on the provider enrollment application.
- A Plus Government Solutions will fax or mail a written request to the designated school office.
- The request will specify the type of documents needed for each claim and will provide instructions on how to submit records.

MEDICAL RECORD REQUEST

- Records may be submitted to the PERM Review Contractor by fax (please number pages), mail, a password protected CD , or the electronic submission of Medical Documentation (esMD).
- For information about esMD, visit; **http://www.cms.gov/esMD/**
- Initial submission: Please include the initial submission coversheet with the PERM ID.
- The PERM ID is a randomly assigned number used by the contractor and state to track the records throughout the audit.
- The PERM ID is usually formatted like: KYM1002F103 or KYC1303F123

TIMEFRAME SUBMISSION

- Initial Requests are due within 75 calendar days from the letter date.
- During this 75 calendar day period, reminder phone calls and written requests will be sent to providers if your records have not been received.
- Once the records are received, the 75 day timeframe will expire.

ADDITIONAL TIMEFRAME

- If the submitted documentation in the record is insufficient to support the claim, a request for additional documentation is sent before the review is completed.
- Providers have 14 calendar days from the request letter date to submit this documentation.
- There is a database called State Medicaid Error Rate Findings (SMERF)that tracks sampled claims, status of medical record receipt and errors that I review.
- I am notified when documentation is submitted or has not been received timely and I will contact respective providers for missing documents.

REVIEWS

- **Medical Review** – conducted on sampled FFS claims and includes review of the provider's medical record supporting the service(s) billed that are applicable with Federal and State regulations and policies to determine whether the service was medically necessary, provided in the appropriate setting, billed correctly, and coded accurately.

- **Data Processing Review** – conducted on sampled FFS and managed care payments. Contractor remotely reviews the claim and other information available in the State's Medicaid Management Information System (MMIS), related systems, or outside sources of provider verification.

MEDICAL CODING REVIEWS

- Six (6) primary elements in medical/coding reviews:
  - Adherence to State specific guidelines and policies
  - Completeness of medical documentation
  - Medical necessity determined based on documentation
  - Validation that services were ordered (need order copy)
  - Validation that services were provided as billed
  - Correct coding based on documentation submitted

AUDITED INFORMATION

- SBHS Providers must maintain documentation of the following:
  - IEP in effect for the date of service sampled which is not necessarily the current IEP.
  - Student attendance records
  - Correct date of service (DOS)
  - Service provided must comply with administrative regulations and policy.
  - Correct member/student
  - Correct covered service/procedure code

AUDITED INFORMATION

- Correct number of units
- Treatment plan and progress notes written legibly.
- Provider must sign and date the record entries.
- Ensure the records are legible – e.g., colored backgrounds on faxed documents are difficult to read.
- Copy both sides of two sided pages when faxing.
- Please note: Marking/highlighting can obscure important facts when copied.

MEDICAL REVIEW ERRORS

- All missing or insufficiently documented services will be deemed a payment error regardless of the amount.
  - Example: $2.64 payment for speech therapy
- MR1 Error- missing documentation-no documentation was submitted.
- MR2 Error – insufficient documentation was received.

MEDICAL REVIEW ERRORS

- MR3 Error– Procedure coding error (the procedure was performed, but was billed using the wrong procedure code)
- MR6 Error- Number of Unit(s) in Error
- MR7 Error– Medically unnecessary service (service was medically unnecessary based on the condition documented in the record in accordance with state policy)
- MR8 Error - Policy Violation (service performed is not in agreement with state policy)

DATA PROCESSING ERRORS

Potential Data Processing Errors

- DP1 Error – Duplicate Claim
- DP2 Error – Non Covered Service
- DP3 Error – FFS claim billed for a managed care service (member was enrolled in MC, but claim was paid under FFS component)

DATA PROCESSING ERRORS

- DP4 Error – Third-party Liability (service should have been paid by a third party, but was instead paid by Medicaid)
- DP5 Error – Pricing Error (payment for service does not correspond with the pricing schedule on file and in effect for the date of service)
- DP6 Error – Logic edit error (a system edit was in place, but was not working correctly and the claim was paid incorrectly)

DATA PROCESSING ERRORS

- DP7 Error – Data entry error (a line item/claim is in error due to clerical errors in the data entry of the claim)
- DP8 Error – Managed Care rate cell error (a member was enrolled in MC and payment was made, but for the wrong rate cell)
- DP9 Error – Managed Care payment error (a member was enrolled in MC and in the correct rate cell, but the amount paid was incorrect)

ERROR NOTIFICATIONS

- Once a claim is deemed in error, the state is notified via email.
- If the state reviews the contractor's decision and does not agree, we file a request for a difference resolution.
- The state is required to provide supporting documentation as to the reason why we dispute the decision.

CORRECTIVE ACTION PLAN

- States must write a Corrective Action Plan (CAP)
- States must analyze the errors.
- Identify the root cause.
- Implement a corrective action.
- If a claim is determined an error, State Medicaid Agencies may pursue recovery of payment for this claim.

CAP EXAMPLES

- CAP examples include:
  - The state may require providers to attend education workshops.
  - The state may conduct further audits including asking providers to conduct self-audits.
  - The state may opt to send provider education and/or demand overpayment letters.

PROVIDER BEST PRACTICES

- Providers should:
  - Be knowledgeable about state Medicaid policies for your provider type.
  - Monitor the state's Medicaid website for policy updates and maintain documentation required by states' policies.
  - Designate a point of contact to handle record requests.

PROVIDER BEST PRACTICES

- Make the request a priority and begin to process it when received.
- Read the request thoroughly, paying close attention to the dates of service requested.
- Research thoroughly with appropriate departments if unable to locate recipient or date of service requested.
- Cross reference name changes.

REPORTING

- CMS submits a final report with those error rate estimates to Congress, and reports on actions the agency is taking to reduce erroneous expenditures.

- CMS and HHS report improper payments annually in the Agency Financial Report (AFR) **http://www.hhs.gov/afr/**

PROVIDER EDUCATION

- CMS hosts provider education webinars/conference calls each PERM cycle. Dates TBD
- The purpose is to provide opportunities for the providers of the Medicaid and KCHIP communities to enhance their understanding of specific Provider responsibilities during the PERM audit.
- You will have the opportunity to ask questions live during the Q&A portion of the conference calls, via the webinar, and through the dedicated PERM Provider email address at; PERMProviders@cms.hhs.gov .

QUESTIONS?

- State contact: Evette Rhodes

  Email: Evette.Rhodes@ky.gov

  Phone: (502) 564-1012 ext. 2150
- CMS PERM Website: http://www.cms.gov/PERM
- Central email for provider questions: PERMProviders@cms.hhs.gov